Doctor-Patient Relationship

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Objectives

- Appreciate the social roles of doctors and patients
- Discuss the Types and Models of Doctor-Patient Relationship (DPR)
- Highlight the importance of effective Communication in DPR
- Appreciate the `the changing scenario in DPR

Contents

1. The nature of **DPR**
2. Factors influencing **DPR**
3. Types of **DPR**
4. Models **DPR**
    1. Transactional Analysis
5. Doctors' Communication skills
6. Changes in the Doctor-Patient Relationship
7. Strategies for improving **DPR**

1- Nature of Doctor-Patient Relationship

- It is an emotional association (clinical encounter) between the doctor and a patient which arises when the doctor in a professional capacity; interact with the patient.

- It is usually related to clinical events, but it is important to realize the association beyond the clinical premise e.g. in the community (non clinical situation).

- Depends not only on Drs' clinical knowledge & skills but also the nature of the social relationship that exists between the Dr & Patient

1- Nature of Doctor-Patient Relationship

- The Doctor and The Patient are on two opposite ends
- The Doctor has a high level of knowledge on a problem the patient almost knows nothing about
- The Doctor is often concerned with the disease diagnosis and treatment (find and fix approach)
- The patient is concerned with illness (disruption of life)
- Its entirely different from mechanic-client relationship

DPR-Why is it relevant to us?

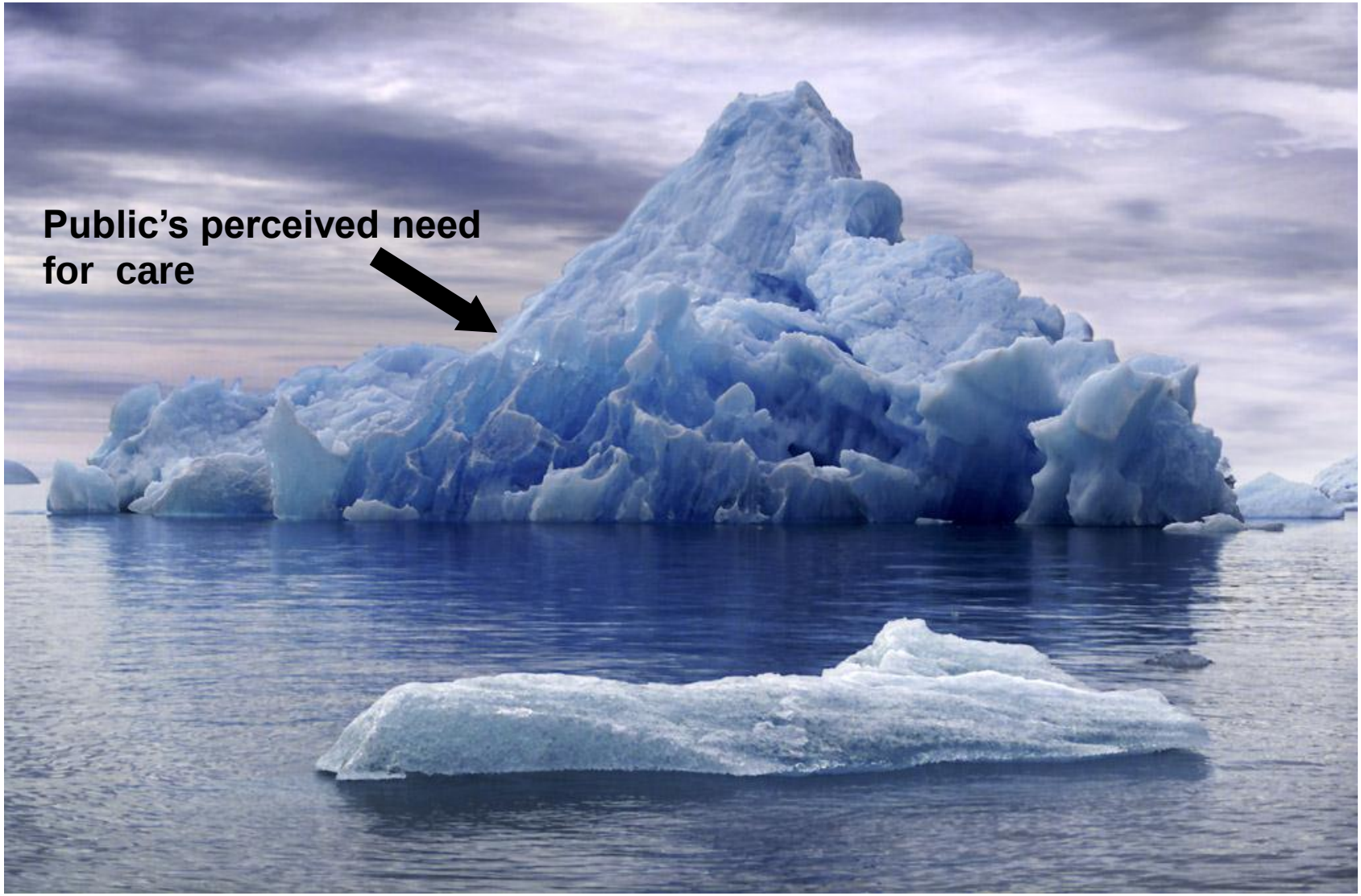
Because of our understanding of:

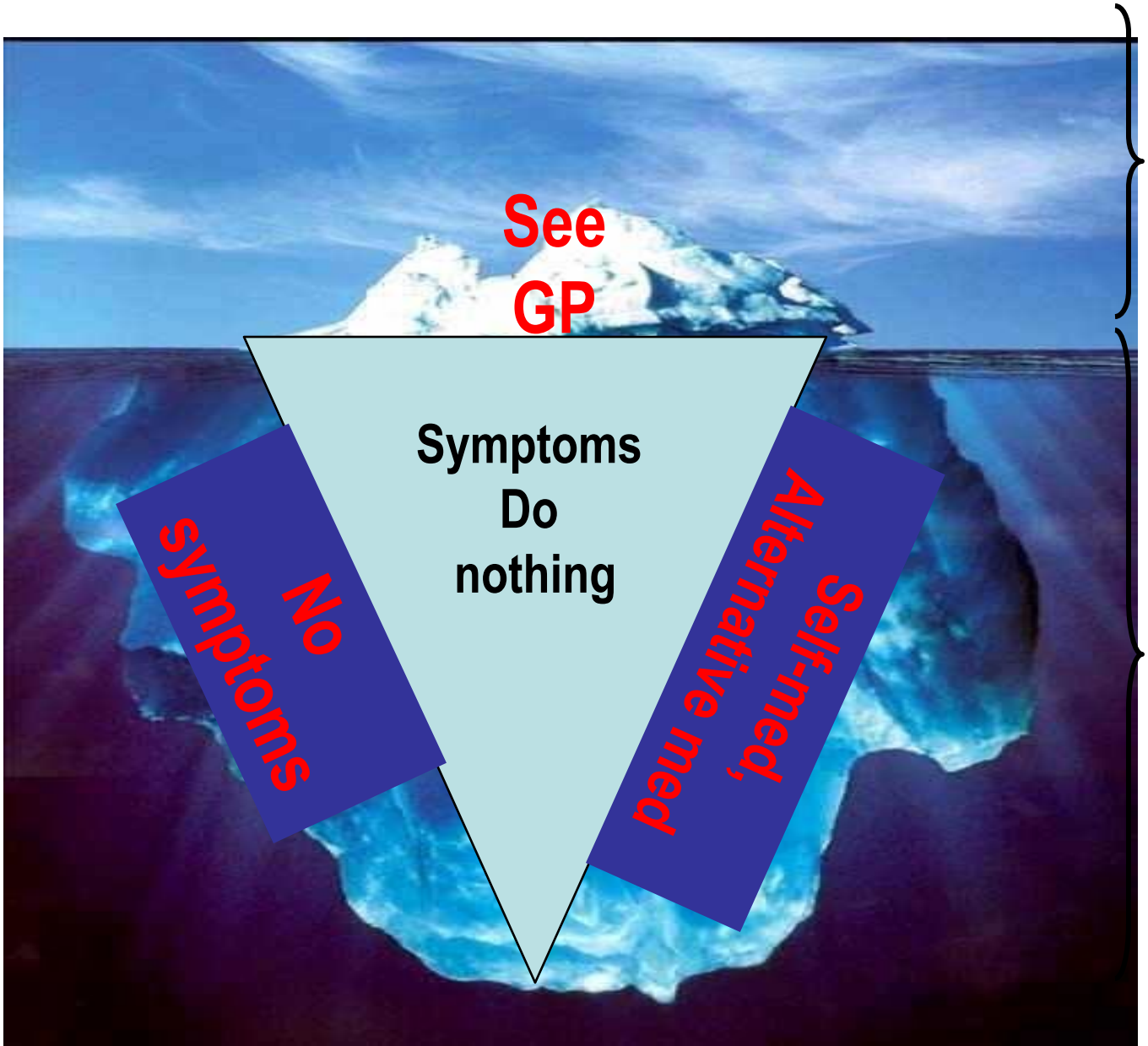
- The Clinical Iceberg phenomena
- The decision making process in illness behavior
- The social triggers of decision to seek medical aid

Perceptions of Need

The clinical iceberg (iceberg theory, last 1963)

- Refers to the gap between the need for medical care and the utilization of professional services.
- Health care professionals only see the tip of the iceberg with respect to the volume of illness in the community


Public's perceived need
for care



Public's perceived need for care

Note the difference between actual and perceived need

Implications

- Treated cases are not representative of sufferers as a whole and that knowledge of disorders obtained by the study of such cases is likely to be biased

- To reduce the gap
  - Appropriate education of both groups
  - Successful Doctor-Patient Consultation

The Decision-Making Process

- 10 variables important in seeking of professional advice (Mechanic,1968)
  - By illness behaviour we mean the way symptoms are perceived, evaluated and acted upon by a person who recognizes some pain, discomfort or other signs of organic malfunction
- Social triggers (Zola,1973)
- A model of Health and Illness behaviour in a multi-ethnic society (Jaafar,1995)

The Decision-Making Process mechanic (1968)

1. The visibility, recognizability & perceptual salience of the symptoms
2. The perceived seriousness of the symptoms
3. The extent to which symptoms disrupt work, family & other social activities
4. The frequency of the appearance of symptoms & their persistence or recurrence
5. The tolerance thresholds of others who are exposed to the symptoms
6. The knowledge, cultural assumptions & understanding of the person and relevant others
7. Other needs or practical matters competing with the illness response
8. Competing possible interactions which can be assigned to symptoms once recognized
9. Emotional barriers in the form of fear and anxiety which influence the choice of actions to deal with the problem
10. The availability, physical proximity and the financial and/or emotional costs of taking various courses of action

Social Triggers (Zola, 1973)

Non physiological 'triggers' to the decision to seek medical aid:

1. An interpersonal crisis
2. Perceived interference with personal relationships
3. 'Sanctioning'; that is, one individual taking primary responsibility for the decision to seek medical aid for someone else (the patient)
4. Perceived interference with work or physical functioning
5. The setting of external time criteria ('If it isn't better in 3 days…..then I'll take care of it')

2- Factors influencing DPR

Factors influencing DPR

Conflict of Interest

- Interests of patient vs. society
- Interests of patient vs. other patients
- Problems of confidentiality

Factors influencing DPR

Differences in perspectives

- social class
- ethnicity
- gender
- clinical-practice style
- Types and models of doctor-patient relationships

Recap…..

- What do you understand by DPR?
- Why do you think it is important?
- What are the factors influencing DPR?

3- Types of Doctor-Patient Relationship

Types of doctor-patient relationships

1. Default
2. Paternalism (Doctor-centred, Disease model)
3. Consumerism (typical in private practice)
4. Mutuality (Patient-centred, illness model)
5. conflict

Exercise

- In Four groups discuss the types of Models
- Present your view

4- Models of DPR Transactional Analysis or TA (Eric Berne 1986)

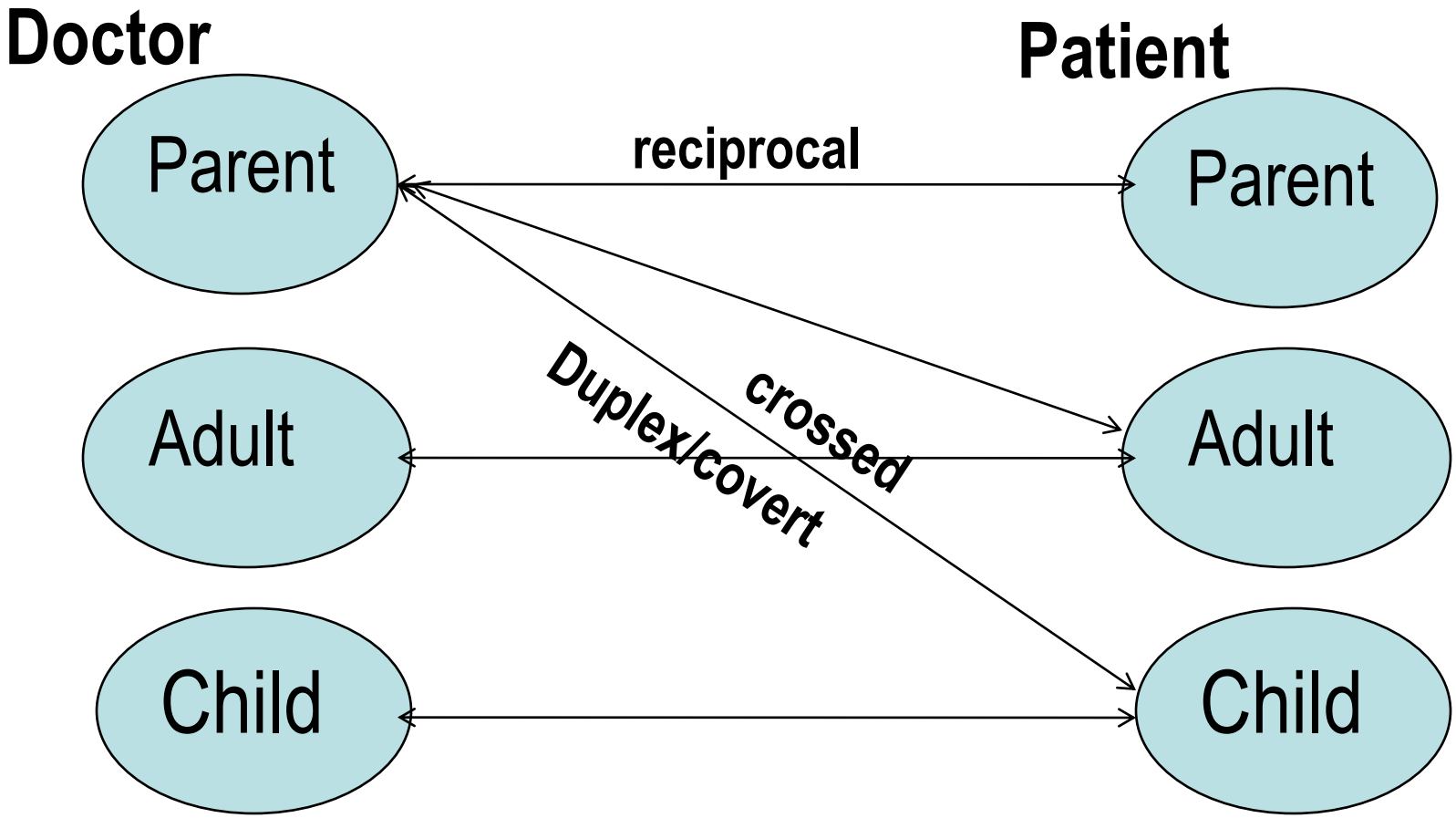
Describes and explains how we relate to each

other by looking at 3 ego states.

Ego states:

- Parent
- Adult
- Child

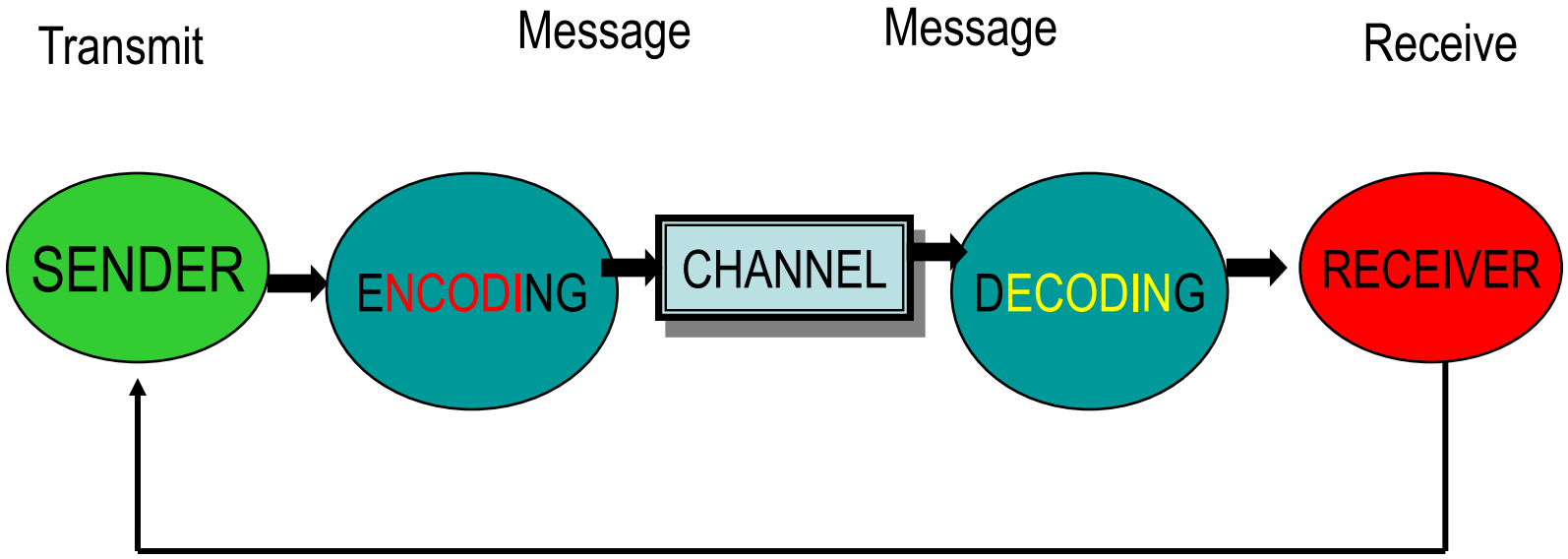
Transactional Analysis



5-DOCTORS'

COMMUNICATION SKILLS

A model of the communication process



Communication

Between doctor and patient

- **Foundation for diagnosis and treatment (elicit & convey information)**
- **Relationship has a therapeutic effect placebo effect of drug**
- **Doctor-centred consultation (Paternalistic style)**
  - **'Closed' nature questions e.g. "How long have you had the pain? & is it sharp or dull?"**
    Diseased centred model talk

Communication

Between doctor and patient

- **'Patient-centered' approach (Mutuality)**
  - Encourage & facilitate their patients to participate
  - Use of 'open' questions e.g**. 'tell me about your pain', 'how do you feel? & 'what do you think is the cause of the problem?'**
  - Active listening skills, requires more time (participative style)

Why is there poor communication?

- The influence of class and status
- Cognitive failure
- Professional attitudes and interviewing styles
- Professional power

Good Communication Skills In Consultation

1. Initiating the session (initial rapport)
2. Gathering information (exploring the problem, understanding the patients views)
3. Building the relationship (involving the patient)
4. Explanation and planning (providing the appropriate amount & type of information, aiding accurate recall and understanding, achieving a shared understanding and planning)
5. Closing the session

Silverman et al, 1998

Non-verbal (Body language)

- ☺ Greet patient, SMILE, polite and gentle
- ☺ Forewarn patient of your next action
- ☺ Facial expression
- ☺ Listening
- ☺ Eye contact
- ☺ Posture
- ☺ Proximity
- ☺ Position
- ☺ Body contact

Verbal

- Social exchanges
- Address the patient accordingly
- Avoid compound question
- Open and focused questions
- Facilitate talking: "Go on…"
- Restating: repeat what patient say in your own words.
- Simple words and speak clearly

Advantages of improved communication

1. Compliance with medical instructions and advice ⇨
   - Low compliance Dr who do not seek pts' active participation in the interview, are formal and distant in their mx of the pt by providing little in the way of feedback
2. Satisfaction with health care
   - Goals of Pt – Dr relation, sharing of any oral problems, relief of fear & anxiety
3. The social dimensions of healing
   - Benefits of improved DPR – satisfactory recovery
   - Significance of **EMPOWERMENT**

6- Changes in the DPR

Wersch & Eccles, 2001 (Development of clinical guidelines for practice)

- Philosophy of patient-centred care
- Shift towards shared treatment decisions
- Greater access to high quality medical information on the internet will increase the no. of ‘information-rich’ pts

Changes in the DPR

- Ridsdale & Hudd, 1994
  - The widespread use of computers in the consultation
    - Position of pt from the screen
    - Drs' ability to maintain their personal touch through verbal skills and eye contact
    - Confidentiality of data ⇒ maintain TRUST
- The use of telemedicine as a means of delivering health care

7- Strategies for improvement of DPR

1. Understanding illness
   - How pts and those around him view origin, significance & prognosis of the condition & how it affects other aspects of life
   - Info about pts' cultural, religious, social & economic background, his previous experience of ill-health, & if possible his view of misfortune in general
2. Improving communication

"Language of distress" - culturally specific folk illnesses (Mechanic)

Helman, 2000

Strategies for improvement of DPR

3. Increasing reflexivity (self-awareness)
4. Treating ‘illness’ and ‘disease’
   - Do not deal with physical abnormalities/malfunctions
   - The many dimensions of **“ILLNESS”**
5. Respecting diversity – health beliefs and practices
6. Assessing role of context (social, economic, environmental factors - focus on who?)

Helman, 2000

CONCLUSION

- **Goal of consultation is not only to arrive at diagnosis and formulating a treatment plan**
- **But also, to develop common understanding between patient and doctor**
- **To help patients develop self control over their illness and its course**

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